EXHIBIT "M"

lunch. We will see you back here in about an hour.

(A luncheon recess was taken.)

THE COURT: Please be seated. Are the parties ready to proceed?

MS. BOOK: Yes, Your Honor.

THE COURT: Defense ready to proceed?

MS. EFFMAN: Yes.

THE COURT: Bring the jury in, please.

(Whereupon, the jury entered the courtroom.)

COURT OFFICER: Jury is entering.

THE COURT: Please be seated. The People may call their next witness.

MS. BOOK: Thank you, Your Honor. The People call Dr. Katrina Kardos to the stand.

KATRINA KARDOS, M.D., after first having been duly sworn by the Clerk of the Court, was examined and testified as follows:

THE CLERK: The sworn witness is Katrina Kardos, K-A-R-D-O-S.

THE COURT: You may proceed.

MS. BOOK: Thank you, Your Honor.

DIRECT EXAMINATION

BY MS. BOOK:

Q. Good afternoon, Doctor.

A. Hi.

Q. Would you please introduce yourself to the jury?

A. I'm Katrina Kardos. I'm a board certified emergency medicine physician at Samaritan Hospital.

Q. How long have you been employed at Samaritan Hospital?

A. For three years.

Q. Can you please tell the jury a little bit about your formal education?

A. I did my undergraduate training at Siena College in Loudonville, New York, for four years. I received a Bachelor of Science in biology, and then I did a year of paramedic school at Hudson Valley Community College, and then I went to Albany Medical College for four years, and then I completed a residency in emergency medicine at Albany Medical Center for three years, and then I joined Samaritan Hospital.

Q. And you said that you were an emergency doctor at Samaritan Hospital?

A. Yes.

Q. Can you explain to us what an emergency doctor does?

A. An emergency physician is a physician who works in the Emergency Department and takes care of patients when they arrive in the hospital and determines their disposition, meaning whether or not they get discharged home to follow up with their doctor, or they get admitted to the hospital.

Q. What state are you licensed in?

A. New York State.

Q. And when were you licensed?

A. In 2006.

Q. Have you been practicing since you were licensed in 2006?

A. Yes.

Q. How many patients would you estimate that you have treated over the course of your career so far?

A. A little over 20,000.

Q. Have you taught or lectured in your field at all?

A. Yes. I have lectured primarily in emergency medicine for pre-hospital care providers, meaning EMT's and paramedics.

Q. Where have you lectured?

A. I have lectured for the Albany Fire Department, as well as for Colonie Emergency Medical Services in New York.

Q. Okay. Let me draw your attention to Sunday, September 21, 2008, at a little after 9:00 a.m. in the morning. Were you on duty that day?

A. Yes.

Q. And were you working in your capacity as an emergency room physician?

A. Yes.

Q. Do you now know someone by the name of M[redacted] T[redacted]

A. Yes.

Q. Can you tell us about the condition in which you came

to know M[redacted] T[redacted]

A. M[redacted] T[redacted] arrived at the Emergency Department on Sunday morning at approximately ten after nine, and he was brought in by Troy Fire Department EMS. He was brought -- shall I continue?

Q. Go ahead.

A. Sorry. He was brought in in critical condition. And when he was brought in, he was actually -- his breathing was being assisted by the paramedics.

Q. How were they assisting his breathing?

A. They were using what's called a bag valve mask, which is a plastic piece of material that you put over the patient's mouth and provide ventilation.

Q. What condition was M[redacted] in when he arrived?

A. He was critical when he arrived. He wasn't breathing on his own very well.

Q. Okay. And when assessing a patient, what do you look for?

A. When a patient first arrives in an Emergency Department, we try to secure and go over their ABC's, and that stands for airway, breathing and circulation. So, the first thing you look at in a patient is are they maintaining their own airway and can they breathe on their own.

Q. Was [redacted] maintaining his own airway?

A. He was not able to maintain his own airway. He

wasn't swallowing on his own. He didn't have good chest rise, and he had some secretions in the back of his mouth that he wasn't swallowing on his own.

Q. Because of this, what did you do?

A. At this point, we intubated the patient, which is when you take a tube and place it in a patient's trachea, and this helps secure the airway and allows us to breathe for the patient, and you can do that manually with a bag valve mask, as we discussed earlier, or you can hook them up to a ventilator.

Q. And what was done with M[redacted]?

A. He was intubated and then hooked up to a ventilator.

Q. Did this ventilator essentially take over breathing for him?

A. Yes.

Q. And can you tell us about the B?

A. B is for breathing, and you want to make sure a person is breathing, able to get oxygen into their lungs, and then that oxygen is able to circulate around their body. When M[redacted] arrived in the Emergency Department, he had very little chest rise. It wasn't adequate to supply oxygen to the body. When you intubate somebody, you then provide artificial respiration, and the ventilator allows the oxygen to get pumped into their lungs.

Q. Can you please tell us about the C?

A. The C is for circulation, and that -- in that

section, you assess their pulse, and not only if they have a pulse. Once you establish they have one, you want to make sure that it's adequate to circulate the blood around their body. And, so, the C also includes blood pressure. When M[redacted] arrived, his pulse was in the 180's, which is a little bit too fast for his age, but it was enough to circulate blood around his body. His blood pressure, when he first arrived, seemed adequate, but changed throughout the course of his stay.

Q. Okay. And what did you do to -- because of the low blood pressure?

A. When a patient like this arrives, we give them IV fluids to help stabilize their blood pressure, and that is what we did for M[redacted].

Q. Did you take any history on M[redacted]s background?

A. Yes. I spoke to both the paramedics and to the patient's mother, and I was informed that the patient hadn't been feeling well for a few days. He had had some vomiting and some diarrhea at home. And the morning that he arrived at the Emergency Department, his mother had told me that, around six o'clock in the morning, he seemed to be doing okay, and throughout the course of the hours before he came to the ED, he seemed to become more fatigued, not responsive, as well, to the point where she was concerned enough where EMS was called.

Q. Okay. And did you make any preliminary determinations about what may have caused his condition?

A. Yes. When a patient comes into the Emergency Department, we have to assess them quickly, and we develop what is called a differential diagnosis, which is a list of potential problems with a patient. So, when a sick child comes into the Emergency Department, things that come through our head are sepsis, which is an overwhelming infection, head injury, abuse, profound dehydration, electrolyte abnormalities. So, these were all on the list of potential problems.

Q. Doctor, taking each differential diagnosis, can you tell us what you did and whether or not you were able to rule that out or not?

A. Yes. For sepsis, this patient did display some signs of infection. And for that, we did give him IV antibiotics, and we choose antibiotics that cover a broad spectrum of infection because, clearly, in that short period of time, we are not able to determine the exact source of the infection.

In terms of head trauma -- when a patient first arrives at the hospital, again, the most important thing to do is the ABC's. And so for him, we never got to a point where we could do a CAT scan of his brain at our hospital, because he was very critical, and we were trying to keep his airway breathing and circulation at an adequate level.

For profound dehydration, we did give him IV fluids, and then we also checked his electrolytes on his lab work. In addition, we did also order blood cultures, which is when you

take blood from a patient. Grown in a culture medium, it takes at least -- typically, it takes at least 24 hours for those results to come back.

Q. Are you now aware, as you sit here today, what the results of those blood cultures were?

A. I was informed that they were positive.

Q. Positive for what, Doctor?

A. For streptococcal pneumonia.

Q. And how is that treated?

A. It depends where the infection actually seeds itself in your body. The human respiratory tract is colonized with streptococcus pneumoniae, a bacteria, and once it invades through the mucous membrane in your body, it can seed in different areas of your body. For example, it can cause bronchial or lobar pneumonia. It can cause ear infection, cellulitis, or an infection of the skin. It can cause meningitis, and it can get into your bloodstream, as well.

Q. Does that mean that all of us have some of those symptoms in our own body at all times?

A. We all have the --

MS. [redacted]: Objection.

THE COURT: Sustained.

Q. Can you tell us about how -- can you tell us about how this would be in a healthy person, please?

A. Our bodies are all covered with bacteria of different

sorts, and streptococcus pneumoniae is a bacteria that we have in our body.

Q. And how is it that that bacteria is activated?

A. Typically, it breaks through a mucosal surface in your body and then becomes an infection.

Q. Okay. Now, going back to the head trauma for just a moment. You said that you were not able to get a CAT scan of M[redacted]'s head that morning?

A. No.

MS. EFFMAN: Objection, leading.

THE COURT: Overruled.

Q. Why is that?

A. When a patient comes into the hospital and they are in critical condition, again, we try to make sure their airway is secured, they are breathing adequately and they have a good circulatory status. In a patient of [redacted]s age of four months, 17 days, Samaritan Hospital in Troy, New York, does not keep that kind of a patient at their hospital. We don't have a pediatric intensive care unit, and we don't have the pediatric intensivists, or the doctors that care for these type of patients. So, our main job is get this patient into our hospital, get them stabilized, and at the same time, prepare them to be transferred to a hospital that can more appropriately care for them. So, during this time period, he was too unstable to actually get to our CAT scan, our CAT

scanner, which is in a different area of the hospital, to get this done.

And second of all, we don't have the pediatric neurosurgeons or neurologists to deal with the potential for there being a positive finding on the CAT scan. So, it's in the child's best interest to be stabilized and not be moved around the ER and get to the -- get to Albany Medical Center quicker.

Q. And was M[redacted] transferred to Albany Medical Center?

A. He was.

Q. How do you go about doing this transfer?

A. Once you get a chance where you can actually step away from the patient for a moment, you make a phone call to Albany Medical Center's Transfer Line, and it's people that are trained to accept transfers to the hospital. I called and spoke to the person at the Transfer Center, and then she spoke to Dr. Edge, the PICU, or Pediatric Intensive Care Unit, attending physician, and he actually got on the phone with me and we discussed the case. He accepted the patient for transfer to his hospital, and he sent his PICU team or team of people from Albany Med that come in the ambulance to pick up the patient and bring them back to their hospital.

Q. And when you were speaking to Dr. Edge on the phone, were you sharing information back and forth?

A. Yes.

Q. In what way?

MS. EFFMAN: Objection, hearsay, Judge.

THE COURT: Ms. Book?

MS. BOOK: Your Honor, hearsay can come in for purposes of medical diagnosis or treatment, which is what it is coming in for the purpose of here.

THE COURT: Overruled.

A. So, yes. I informed Dr. Edge of everything I knew about the child, his history, and we reviewed his vital signs and we discussed further care of the patient. During the stay at the hospital, he was very unstable, and his blood pressure kept dropping, and he was being given fluids, and we discussed giving him additional medications to stabilize his blood pressure.

Q. So, did you share with Dr. Edge his entire medical history as you took it?

A. To my knowledge, yes.

Q. Okay. And were you also following some of the advice of Dr. Edge in treating M[redacted] that morning?

A. Yes.

MS. EFFMAN: Objection, goes to hearsay, Judge.

THE COURT: Overruled.

Q. Who was with M[redacted] that morning, if you remember?

A. His mother arrived with him.

Q. And was M[redacted]'s father there?

A. No.

Q. Did you ever have a chance to speak to M[redacted]'s father?

A. Yes. I spoke with him over the phone.

Q. Okay. And can you tell us, briefly, what did that conversation consist of?

MS. EFFMAN: Objection, hearsay.

THE COURT: Sustained.

Q. Okay. When you spoke to the child's father on the phone, about how long was the conversation?

MS. EFFMAN: Objection, relevance.

THE COURT: Overruled.

A. Thirty to 45 seconds.

Q. Okay. And did you turn the phone back over to the child's mother after you spoke to the father?

A. No.

Q. Okay. And why not?

A. She stayed in the room with the child, and he did not ask to speak to anybody.

Q. Did he ask you any follow-up questions?

MS. EFFMAN: Objection, calls for hearsay.

THE COURT: Sustained.

MS. BOOK: Your Honor, I'm not asking for the contents of the conversation, just whether or not -- not for the truth of the matter asserted but for what she did

next.

MS. EFFMAN: It's still hearsay, asking what he did or didn't say.

THE COURT: I think the question was - maybe I misheard it - was "And did he ask you anything?"

MS. BOOK: Did he ask any follow-up questions, Your Honor.

THE COURT: Okay. The witness can answer that question.

Q. Go ahead. You may answer, Doctor.

A. He asked me, "Is he going to make it?"

Q. Okay. Any follow-up after that?

A. No.

MS. EFFMAN: Objection, hearsay.

THE COURT: Sustained. The question being asked, did he ask any follow-up questions, the content of that is hearsay, and it's inadmissible.

Q. Without telling us the answer, did he ask any follow-up questions?

MS. EFFMAN: Still asks for hearsay. I object to that, Judge.

THE COURT: The witness can answer the question as to whether he asked any follow-up questions. The witness cannot reveal the contents of those questions or what the Defendant may have asked, because it is hearsay.

A. Yes.

Q. Did he ask any follow-up questions after what you just said?

A. No.

Q. Thank you. How long, total, was M[redacted] at Samaritan Hospital?

A. Just over two hours.

Q. And what was his condition when he left the hospital?

A. Critical.

MS. BOOK: No further questions at this time.

THE COURT: Thank you. Ms. Effman?

CROSS-EXAMINATION

BY MS. EFFMAN:

Q. Good afternoon, Dr. Kardos.

A. Hi. How are you?

Q. When you first saw this baby in the emergency room, the T[redacted] baby, you were provided with a history concerning the baby's health and the days leading up to him coming to Samaritan Hospital; correct?

A. Yes.

Q. And part of this history concerned the temperature the baby had had; correct?

A. Yes.

Q. What, if any, information were you given that morning concerning the baby's temperature just prior to coming to

Samaritan Hospital?

A. His mother had told me that his temperature at home was 100.4 degrees rectally.

Q. And Doctor, is a rectal temperature the most accurate way to take a baby's temperature?

A. Yes.

Q. And what is the average, normal temperature, a healthy infant or healthy child's temperature you would expect of a child that has no illness and is feeling well?

A. 98.6.

Q. Prior to taking his history, were you given any information concerning his respirations as he arrived to the hospital?

A. The paramedics had told me that when they arrived at the child's home, his respiratory rate was what's called agonal, or very minimal, about four to five times per minute.

Q. And based upon your training and experience as an emergency room doctor, what would be the normal respiratory rate of breaths per minute that you would like to see in a normal, healthy baby?

A. Thirty to 60 breaths per minute.

Q. A physical examination was done by yourself of the entire body of the T[redacted] baby; correct?

A. Nearly the entire body.

Q. And during the examination, no bruises were found;

correct?

A. Correct.

Q. No contusions?

A. Correct, no.

Q. And that's another word for a bruise; correct?

A. Yes.

Q. You found no abrasions; correct?

A. Correct.

Q. Based on what you found, the child was in severe respiratory distress?

A. Severe respiratory distress and not normally responsive.

Q. Based on your initial assessment, you thought this child might have a bacterial infection; correct?

A. Correct.

Q. And based on that, you ordered him to receive two different antibiotics as part of the care and treatment you rendered at Samaritan Hospital?

A. Yes.

Q. Correct? And one of the antibiotics was Ceftriaxone?

A. Yes.

Q. And that is given to treat a bacterial infection; right?

A. Yes.

Q. And that can be used to treat something like

meningitis; correct?

A. Yes.

Q. You also gave him an antibiotic called Vancomycin?

A. Vancomycin.

Q. Vancomycin. That's also used to treat bacterial infections, too; correct?

A. Correct.

Q. Let's talk about the baby's health upon his arrival. I understand, on his arrival, as you testified, he wasn't able to breathe on his own; correct?

A. Correct.

Q. He came to you with a bag mask. And during his time that he was at Samaritan Hospital, he was on the ventilator for awhile, and he also went back on a bag mask while he was at Samaritan Hospital; correct?

A. Correct.

Q. In fact, the whole time he was at Samaritan Hospital, he had some breathing problems; correct?

A. Correct.

Q. And he was never really stable the whole time he was there; correct?

A. Correct.

Q. Let's talk about his blood pressure, Doctor. During the time that he was at Samaritan Hospital, his blood pressure dropped pretty significantly; correct?

A. Yes.

Q. At some point in time, I guess -- on a normal, healthy baby of this age, four months, what type of blood pressure would you like to see in a normal, healthy child?

A. A formula you can use for this is for a normal blood pressure would be 90 plus two times the age in years, and then the lowest acceptable blood pressure would be 70 plus two times the age in years for the systolic blood pressure, or the top number.

Q. So, translating that for the jury, a baby of this age of this particular child, M[redacted], translate for myself, as well, what number -- what would be the range of blood pressure you would like to see, assuming the child is healthy when they are brought to the emergency room?

A. Someone that's four months old, 65 to 90 for the systolic or the top number.

Q. And while he was there, his blood pressure dropped down to the 50's, correct, as a top number?

A. To the 40's.

Q. Lower than that. Down to the 40's?

A. Yes.

Q. Okay. Actually, it became dangerously low, correct, Doctor?

A. Yes.

Q. And that would have been of great concern to you;

correct?

A. Correct.

Q. Let's talk about his body temperature. You testified that it was 97.2 when he arrived. During the hour and a half or so that he was at your hospital, his temperature, body temperature continued to drop; correct?

A. Correct.

Q. And in fact, blankets were brought down, warm blankets were brought to him to try to make the baby warmer; correct?

A. Initially blankets, followed by a warmer from Maternity, which is basically a heat lamp.

Q. And despite those things, this baby's temperature dropped to 94 degrees or so while he was at Samaritan Hospital?

A. Yes.

Q. And would you consider that hypothermic?

A. Yes.

Q. And tell the jury, what is hypothermia?

A. Hypothermia is a body temperature that's lower than normal.

Q. And what is the average body temperature?

A. 98.6.

Q. So, along with the low blood pressure, this low temperature, obviously, Doctor, would have been of great concern to you?

A. Yes.

Q. Let's talk about his white blood cell count. Shortly after his arrival at the hospital, you ordered that some blood be drawn to be tested and analyzed at the lab at Samaritan Hospital; correct?

A. Yes.

Q. You wanted to see what his blood counts were; correct?

A. Yes.

Q. And tell the jury what you look for when you look at blood counts and why it's important to get a blood count on an ill child?

A. Your blood count can change for many different reasons. It can go up or down. In a case like this, if you are concerned about the possibility for infection, if the white cell count -- classically, it will go up. However, if your body actually has a severe infection, then it's using up its white blood cells faster than they can be produced. It will go down. In addition, we also look at his red blood cell count, his hemoglobin and hematocrit, to make sure he's not bleeding internally somewhere.

Q. When you got the white blood cell count back, that white blood cell count for the T[redacted] baby was very low; wasn't it?

A. It was low.

Q. What's the range of a healthy person or baby of this age, white blood cell count?

A. 3,000 to 10,000.

Q. And what was the white blood cell count of M[redacted] T[redacted]?

A. 1,000.

Q. And Doctor, his platelet count was low, as well; correct?

A. I would have to look back. I don't remember.

Q. I will mark a copy of the records for you to look at.

(Samaritan Hospital Medical Records marked Defendant's Exhibits A and B for identification.)

Q. Would looking at a certified copy of the Samaritan Hospital records refresh your memory as to the platelet count on this child as he -- after his blood was tested by Samaritan Hospital?

A. His platelet count was 175.

Q. And what's the average range of a platelet count?

A. 150 to 400.

Q. And in terms of the records -- if I can have this back, Doctor. And Doctor, in terms of that date -- the record you looked at actually refers to September 22, 2009. The date that you saw this child would have been September 21st; correct?

A. Correct.

Q. Looking at Defendant's Exhibit B, which refers to blood tests done on September 21st, the date when you saw this baby, could you tell the jury if that document refreshes your recollection of the platelet count on September 21, 2008?

A. 115.

Q. And that's below the average recommended range?

A. Yes.

Q. Were there any other abnormal or low tests that came back on this baby when his blood was tested at Samaritan Hospital that morning?

A. His white count and his platelets were low.

Q. Were there any other tests or blood components that were not in the normal range?

A. According to the lab work, it says that his hemoglobin and his hematocrit were low. However, in a child of this age, these numbers are actually acceptable. Sometimes the normal reference range that the lab gives doesn't reflect the age of the patient. So, in my professional opinion, the white count and the platelets were low for his age.

Q. Why is a white blood cell count important, Doctor?

A. It shows your body's ability to mount a response against an infection.

Q. In fact, you diagnosed this baby as suffering from leukopenia; correct?

A. Yes.

Q. Can you tell the jury, what is leukopenia?

A. Leukopenia means low white blood cells. White blood cells are also known as leukocytes. So, leukopenia is low white blood.

Q. And that would have been of concern to you, Doctor, of this baby?

A. Yes.

Q. So, someone who has a low white blood cell count has a decreased ability to fight off infection; correct?

A. Correct.

Q. While the T[redacted] baby was at the hospital, you ordered a blood culture be done of this baby; correct?

A. Correct.

Q. And what does a blood culture test for?

A. A blood culture tests to see if there's bacteria growing in the blood.

Q. And those results usually take a day or two to come back; correct?

A. Yes.

Q. And those are not done actually at Samaritan Hospital; they are sent to an outside hospital?

A. I'm not sure.

Q. Now, while you were treating the T[redacted] baby, did you get back the results of a blood culture that was drawn that morning?

A. No.
Q. In fact, those came back thereafter; correct?
A. Correct.
Q. You already testified that you are aware that they had a positive test for streptococcus pneumoniae; correct?
A. Right, correct. I was recently made aware.
Q. And streptococcus pneumoniae can cause a variety of things; correct?
A. Correct.
Q. Can cause pneumonia?
A. Yes.
Q. It can cause bacteremia?
A. Yes.
Q. And that is bacteria in the blood?
A. Yes.
Q. It can cause an ear infection?
A. Yes.
Q. And the streptococcus pneumonia that was diagnosed as being in his blood, streptococcus pneumoniae, that bacteria can also be a possible cause of meningitis. Isn't that correct?
A. Yes.
Q. Tell the jury, what is meningitis?
A. Meningitis is an inflammation of the meninges. The meninges is essentially a layer of saran wrap that surrounds your brain and your spinal cord, and it can become inflamed for

a variety of reasons. Included in those reasons are viral infection, fungal infection, bacterial infection and trauma.

Q. When [redacted] first arrived, when the baby first arrived at the hospital, his blood sugars were tested; correct?

A. Correct.

Q. And those were below normal; correct?

A. Correct.

Q. What was his blood sugar level count? And if you don't know, I can give you the document to refresh your recollection, Doctor.

A. I believe it was 50, but I would have to look to be sure.

Q. I show you what's been marked as Defendant's A for your review.

A. I'm not sure if this is the right paperwork. This has Adrian Thomas on it.

MS. EFFMAN: I will have this marked.

(Samaritan Hospital Medical Records marked Defendant's Exhibit C for identification.)

Q. Would looking at a copy of the records of M[redacted] T[redacted] refresh your recollection as to what his blood sugar level was?

A. Fifty.

Q. And what is the glucose level that you would like to see in a normal, healthy infant?

A. More in the range of 70 to 90.

Q. What can happen if someone's glucose level or an infant's glucose level gets too low?

A. It can have an alteration in the level of consciousness. They can make him sweaty, agitated or have a decreased level of consciousness, as well.

Q. A chest x-ray was done at Samaritan Hospital; correct?

A. Correct.

Q. And that showed increased congestion; right?

A. Yes.

Q. And you wrote in your report concerning Mr. Thomas, or the T[redacted] baby, that you thought it was possibly due to acute respiratory distress syndrome, ARDS?

A. Yes.

Q. Can you tell the jury, what is acute respiratory distress syndrome?

A. Acute respiratory distress syndrome is essentially an inflammation of your lungs. When your lungs become inflamed, the tissue of the lungs and the vessels of the lungs become weaker, and fluid can leak out of the vessels into the lung tissue itself, causing fluid in the lungs and more inflammation of the lungs, as well.

Q. In fact, sepsis can cause ARDS; correct?

A. Correct.

Q. You did a differential diagnosis for this baby as part of your job as an emergency room doctor. And in your differential diagnosis, you listed septic shock as a potential cause of this baby's problems; correct?

A. Correct.

Q. In fact, that's the first thing you listed on your report as a possible cause of the baby's problems; correct?

A. Yes.

Q. Can you tell the jury, first of all, what is septic shock?

A. A sepsis in general is whole body inflammatory state, and it's classically characterized by the presence of an infection or the -- that you suspect an infection. With this, there's different signs and symptoms you get with sepsis.

Q. What are some typical signs that come along with sepsis?

A. Rapid heart rate, low blood pressure, hypothermia. You can get a low glucose level, as well.

Q. And what is septic shock?

A. Septic shock, per se, is when your body isn't able to maintain perfusion to your organs because of the overwhelming infection.

Q. What is the word perfusion?

A. I'm sorry, improper blood flow to the organs. For example, if your body can't supply -- if you don't have a well

enough blood pressure, your body can't get blood and nutrients and oxygen to your kidneys, heart, lungs and brain.

Q. During the course of time that this baby was at Samaritan Hospital, you felt that his heart rate at times was tachycardic; correct?

A. Correct.

Q. Can you tell the jury what tachycardia or tachycardic means?

A. Tachycardia is an elevated or high heart rate.

Q. And what happens to your body if you are experiencing septic shock?

A. Your body tries to compensate for the shock. When your blood pressure goes down, your body compensates by increasing its heart rate to try to push whatever blood and oxygen and nutrients it has around the organs. If it gets to a point where that's not successful, your body will start to shut down certain organs.

Q. And when your body begins to shut down, your body systems stop working properly; correct?

A. Correct.

Q. Your body loses its ability to control its temperature?

A. Yes.

Q. Respiratory system would shut down?

A. Correct.

Q. Circulatory system would shut down?
A. Correct.
Q. And your body's ability to protect itself from infection, like your immune system, that would shut down, too?
A. Correct.
Q. How do you treat septic shock?
A. Septic shock is initially treated with IV fluids and an IV antibiotic.
Q. It's actually a life-threatening condition; isn't it, Doctor?
A. Yes.
Q. If not treated quickly, it can result in death; correct?
A. Correct.
Q. And especially so for those who are elderly and the very young; correct?
A. Correct.
Q. Dr. Kardos, this baby had a number of signs that are consistent with sepsis; correct?
A. Correct.
Q. The baby had respiratory distress; correct?
A. Correct.
Q. And that's a sign of sepsis?
A. Yes.
Q. The baby had trouble maintaining his heart rate and

was tachycardic or suffering from tachycardia, and that's a sign of sepsis; correct?

A. Correct.

Q. The baby had an abnormally low body temperature; correct?

A. Correct.

Q. And that is a sign of sepsis?

A. Yes.

Q. The baby had a low white blood cell count, and that's a sign of sepsis, as well; correct?

A. Yes.

Q. The baby had low blood sugar, was hypoglycemic, and that is a sign of sepsis, too; correct?

A. Yes.

Q. And the baby also had low blood pressure, hypotension; correct?

A. Correct.

Q. And that's a sign of sepsis, as well?

A. Correct.

Q. And in fact, this baby showed numerous signs consistent with sepsis; correct?

A. Correct.

Q. When you did your provisional -- you did a provisional diagnosis, Doctor. What is a provisional diagnosis?

A. It's a diagnosis that we can come up with in the brief period of time that we take care of a patient in the Emergency Department. There are times when we can't determine the exact diagnosis, given that we don't have the patient to care for them long enough for all their diagnoses to become evident.

Q. Your provisional diagnosis for this baby was respiratory failure, leukopenia, hypotension, tachycardia and bradycardia; correct?

A. Correct.

Q. And those are all conditions that are caused by sepsis; correct?

A. Correct.

Q. Isn't it true, Doctor, the likely cause of this baby's problems was sepsis?

A. Yes.

MS. EFFMAN: At this time, Judge, I'd move into evidence a certified copy of the Samaritan Hospital blood records, as well as a certified copy of the records that Dr. Kardos has for this baby.

THE COURT: What are they marked for ID?

MS. EFFMAN: Defendant's B and C, and subject to any redactions we may need to discuss concerning any hearsay in those documents.

THE COURT: People's position?

MS. BOOK: May we approach, Your Honor?

THE COURT: Yes.

(Proceedings continue at the bench outside of the hearing of the jury as follows:)

MS. BOOK: Your Honor, we object to the admission of any medical records in this case. It's my understanding from talking to Ms. Effman and Mr. Frost earlier that they intend to call experts in this case. To have all the voluminous medical records in this case contained on that table marked, Your Honor, it's my position that these medical records are too voluminous and too complicated for the jury to understand. Even after weeks and weeks of us reviewing this, not being doctors, there's still a lot of complicated things in here. We are putting the jury in a position to go back to the jury room, read all these records that they are not going to understand, and putting them in a position of basically speculating on what they say. It's our position that they should be -- that the jury should hear all of the testimony of the doctors, obviously, but that that is what they should be able to consider, rather than the medical records in this case. They are not going to be able to understand all these pages of all these medical records. They can't go through page by page of the doctors' records to explain it. It's simply going to be too confusing.

THE COURT: Under that rationale, medical records would never come into evidence.

MS. BOOK: I think there's limited circumstances, but expecting the jury to review packets and packets of medical evidence like we have in this case -- we know how voluminous they are. It's too much for them to comprehend.

THE COURT: Is that your sole objection?

MS. BOOK: And that I believe hearsay is contained therein, like personal medical information, like Social Security numbers, and other things are contained therein. I object to that. Nothing has been redacted at this point.

MR. FROST: Our position is simply this. We are moving them in. We are only asking for a concession as to the foundation; that they are hospital records made and kept in the course of business. If they have objections to certain parts, they can object to certain parts. I think we can probably address them separately. They will not be shown to the jury now. By the time the jury gets to this issue, we will have the benefit of everyone's arguments and the Court's ruling. And to the extent they are referred to in the examination of the witness, I think the Court can deal with any issues of hearsay or opinion or personal information. But otherwise, I don't think

it's an appropriate objection. As the Court says, if that were the case, medical records would never get in.

MS. BOOK: In addition, Your Honor, we have this witness' testimony.

THE COURT: The objection that the records are inadmissible on the grounds that they are too voluminous and would confuse the jury and are certain to bolster, those objections are overruled. The records will be received into evidence subject to the appropriate redactions or any hearsay issues. So, before they will obviously be shown to the jury, which will be some time from now, we will have to deal with the issues of hearsay. With that exception, the records will be received in evidence.

(Proceedings continue in open court as follows:)

THE COURT: Ms. Effman, if you would identify which they were again?

MS. EFFMAN: Defendant's B and C offered in evidence.

THE COURT: Defendant's B and C are received in evidence over objection from the People.

(Defendant's Exhibits B and C marked for identification received in evidence and marked Defendant's Exhibits B and C in evidence.)

MS. EFFMAN: I have no further questions.

THE COURT: Any redirect from the People?

MS. BOOK: Yes, Your Honor.

REDIRECT EXAMINATION

BY MS. BOOK:

Q. Dr. Kardos, did you treat M[redacted] T[redacted] for septic shock that morning?

A. Yes.

Q. So, was he already getting the benefit of those medicines administered to him starting on Sunday, September 21st?

A. Yes.

Q. And when you made your provisional diagnosis of septic shock, did you have the benefit of a CAT scan of the baby's brain at that point?

A. The sepsis was a -- was a differential diagnosis, and at that point in time, I did not have the CAT scan result.

Q. Could a head injury contribute to sepsis?

MS. EFFMAN: Objection.

MS. BOOK: What basis?

MS. EFFMAN: Speculation.

THE COURT: Overruled.

Q. Could it?

A. Head injury can cause an alteration in your level of consciousness, and it can -- it's possible that it can result in an inability to protect your airway, which can lead to

aspiration, a cause of infection.

MS. BOOK: Thank you, Doctor. No further questions.

RECROSS-EXAMINATION

BY MS. EFFMAN:

Q. Doctor, from the time this child had been given medication at Samaritan Hospital, the Ceftriaxone and the -- I'm going to slaughter the name of it. Vancomycin?

A. Vancomycin.

Q. His blood had already been drawn at that point in time; correct?

A. Correct.

Q. So, that medication would not have been in his system at the time the blood culture was drawn and the time his blood was drawn to do a blood count?

A. Correct.

Q. Doctor, in light of all these conditions we have talked about today, the low blood pressure, the hypothermia, the leukopenia, the tachycardia, the conditions that are consistent with sepsis, isn't it true that, despite any of your efforts, it's just as likely this child would have died?

A. It's difficult to answer.

Q. Certainly, this child's chances of survival, based on all these different conditions you observed at Samaritan Hospital that are consistent with sepsis and septic shock, put

him at grave risk of death; correct?

A. Yes.

MS. EFFMAN: No further questions.

MS. BOOK: Can I have one moment, Your Honor?

THE COURT: Certainly.

MS. BOOK: Nothing further, Your Honor. Thank you.

THE COURT: Doctor, thank you very much for your time. You are all set. The People may call their next witness.

MS. BOOK: The People call Wilhemina Hicks.

MS. EFFMAN: Your Honor, may we approach briefly?

THE COURT: Yes.

(Sidebar discussion held as follow:)

MS. EFFMAN: Your Honor, I would just ask the witness be reminded, as this is close in time to the testimony, that she be advised about the discipline issue.

MS. BOOK: I reminded her.

THE COURT: Thank you.

(Photographs marked People's Exhibits 2 through 10 for identification.)

WILHEMINA HICKS, after first having been duly sworn by the Clerk of the Court, was examined and testified as follows:

THE CLERK: The sworn witness is Wilhemina